

Debate 3

Psychoanalysis and analytic psychotherapy in the NHS – a problem for medical ethics

Greg Wilkinson *Institute of Psychiatry, London*

Author's abstract

I question the place of psychoanalysis and psychoanalytically oriented psychotherapy in the National Health Service (NHS), with reference to published material; and, particularly, in relation to primary care, health economics and medical ethics. I argue that there are pressing clinical, research, economic, and ethical reasons in support of the contention that an urgent review of the extent and impact of psychoanalytic practices in the health service is called for.

Psychoanalysis and its main derivative, psychoanalytically oriented psychotherapy, have established a place in the British National Health Service. However, the large extent and dubious impact of this movement is not known in detail. Clearly, its influence is not only restricted to psychiatry, but also extends to other areas in medicine for example, via Balint, to general practice. Similarly, psychoanalytic practices are not solely limited to the medical profession; other professionals, for example, nurses, social workers, counsellors, and clerics, evidently use such techniques in their work. For these reasons, and because the 'Periodic reassessment of the cost, efficiency, and effectiveness of treatment modalities is paramount among the ethical responsibilities of the health care giver' (1), it seems necessary, again, to question the place of psychoanalytic endeavours within the National Health Service (2), in particular, whether they may be justified by the results of empirical research. I approach the topic from the point of view of the primacy of primary medical care; and I support my argument with reference to the disciplines of health economics and medical ethics.

The nature of psychoanalytic practices

Dare's (3) sympathetic description of psychoanalytic practice is clear and unambiguous, and is a convenient starting point for this discussion, demonstrating, as it does, the indeterminable nature of the psychoanalytic

exercise: 'The peculiar nature of the psychoanalytic treatment setting consists in the unusual feature of the communications. The patient is encouraged to speak simply and as completely as possible the thoughts that come into his mind. The psychoanalyst gives no commitment to speak or respond in any way, other than to facilitate the flow and understanding of the supposedly underlying meaning of the thoughts. Questions from the patient are unlikely to be regularly answered and requests for reassurance about the patient's present condition or its future course will not, usually, elicit a response. Yet the psychoanalyst expresses a concerned and detailed interest in all aspects of the patient's life and devotes up to two hundred hours a year to helping the patient. This devotion, combined with the unpredictability and peculiarities of the timing of the psychoanalyst's responses and the rule of free association give a special quality to the nature of the material expressed by the patient'. A very special quality, indeed; and peculiar devotion, but at what price?

The remainder of this essay is concerned with this issue, the costs and benefits of psychoanalytic psychotherapy, in so far as they may involve the health service; but, at the outset, bearing in mind also, a) the general scope of, and b) progress in, psychoanalytic pursuits. First, 'psychoanalysis' has come to refer to a framework which, apart from its involvement in medical training, treatment and research, is a 'quasi-political organisation' (3) attempting to influence the training of psychiatrists, clinical psychologists and social workers. All, as it happens, in keeping with the recommendations made by the Royal College of Psychiatrists (4) as regards the educational role of the consultant psychotherapist. Secondly, after one hundred years of psychotherapeutic practice (the major field of activity of psychoanalysts), developments in psychoanalysis, have been summarised pithily as 'The change away from a model emphasising the impingement of specific drives towards an accentuation of the object-attaching quality of the thrust of mental life' (3).

Key words

Psychoanalysis; psychoanalytic psychotherapy; psychotherapy; National Health Service; primary health care; economics.

Research on the efficacy of psychoanalytic treatments

In 1984 no less than five editorials in prominent

medical journals (5–9) were critical of the research evidence that has so far come forth in support of the general effectiveness of psychotherapeutic treatments. All five stemmed from an article in *The Behavioural and Brain Sciences* (10), which concerned a statistical meta-analysis of a collected group of psychotherapy versus placebo treatment studies. The authors' conclusion cannot easily be dismissed: 'The only studies clearly demonstrating significant effects of psychotherapy were the ones that did not use real patients . . . for real patients there is no evidence that the benefits of psychotherapy are greater than those of placebo treatment'.

Despite this, the psychotherapy lobby seems unruffled (11). A recent paper, by a psychotherapist (12), posed the questions: 'How can we compare different psychotherapies? Why are they all effective?'. So far as the consultant psychotherapist's role in research is concerned, the unusual strategy recommended by the Royal College of Psychiatrists (4) seems, among other things, to have put the cart before the horse: 'there is great need for research and evaluative studies in psychotherapy, not only into indications for the variety of psychotherapeutic interventions, but also into the effectiveness of the various plans for the overall provision of psychotherapeutic care. Research into psychotherapy is essential, but only when psychotherapy services are adequately staffed will psychotherapists have sufficient time to conduct it'.

Malan (13), a prominent British psychoanalyst, comes more to the point: 'the evidence in favour of dynamic therapy in the ordinary run of neuroses and character disorders – for which after all, this form of therapy was developed – is weak in the extreme . . . [research on]. . . the most influential and ambitious of all forms of psychotherapy, that based on psychoanalysis, has yielded almost nothing – a matter for shame and despair – until it has been saved at the last moment by the Menninger Foundation's final report'. In view of the findings therein, this turns out to be a most curious judgement. The report to which Malan refers summarises investigations of the treatment of forty-two patients, by psychoanalysis, over a period of eighteen years (14). The authors state that they found it impossible: to list the variables needed to test the theory of psychoanalysis; to choose and provide control conditions which could rule out alternative explanations for results; to state the hypotheses to be tested; or finally, to conduct the research according to the design.

Even a more recent, impressive investigation, comparing the effects of psychoanalytically oriented psychotherapy and behaviour therapy (15), unfortunately, for methodological reasons, also provided rather inconclusive results.

Psychoanalytic practices and primary care

The patients whom psychoanalytic psychotherapies are alleged to benefit are, in general, those with

disorders of character and those with neurotic mental conditions. It was shown twenty years ago (16), that the vast bulk of such 'minor psychiatric disorders' occur in the primary-care setting. However, the results of clinical trials involving psychoanalytically oriented psychotherapy in general practice are no more reassuring than those quoted above (17).

It would be germane to consider the views of general medical practitioners on this subject. By chance, a paper entitled *A Future Pattern of Psychiatric Services and its Educational Implications: some Suggestions* (18) dealt, indirectly, with this matter. In the study, 29 psychiatric resources were ranked by 314 general practitioners within the former Merton, Sutton and Wandsworth Area Health Authority. Of the various resources, individual psychotherapy was ranked seventeenth, just below community psychiatric nurse and just above sheltered workshops. For what it is worth, family psychotherapy, group psychotherapy, and lay counselling services were ranked twenty-seventh, twenty-eighth and twenty-ninth, respectively. The authors respond with a degree of understatement: 'The high ranking in terms of the perceived importance for out-patient psychiatric services and the lower rating for sub-specialities such as psychotherapy is noteworthy'.

In an impressive review of primary health care, for the Department of Health and Social Services, Donald Hicks (19) adds a number of other dimensions to the debate, introducing, significantly, an ethical perspective to the argument, to which I return below. He includes some discussion of the influence of Balint seminars on general medical practice, a subject to which he devotes some appropriate, hard-headed thought: 'This is a form of apprenticeship in which through the seminars, the general practitioners would learn to do psychotherapy under supervision. It is doubtful if the majority of practising general practitioners would be prepared to serve such an apprenticeship, even if the facilities were available. I believe that we have to recognise that there may well be in the profession, and with the public generally, a certain deep-set resistance towards psychiatry and towards psychotherapeutic methods of treatment of the common complaints of mental ill-health in the community. In any case, doctors do not readily surrender their patients to a method of treatment which they do not understand and the outcome of which may be uncertain in their experience'. Similar doubts about the value of Balint's psychoanalytic contribution in general practice have been expressed, at length, elsewhere (20, 21).

Health economics

Dr Mark Aveline (22), a Nottingham psychotherapist, has posed the following important economic questions on the subject of psychotherapeutic activities within the National Health Service. 'Will NHS psychotherapy direct resources from more needy groups? Who can judge need? Is psychotherapy to be

preferred to renal dialysis or to care of the chronically psychotic?’

A critique of his vague and unsubstantiated opinions on these topics is called for. First, Aveline's comments on psychotherapy in the NHS reveal substantial ignorance about the social and epidemiological context of the subject. This theme is taken up by Cooper (5), who stresses that ‘the idea of need, as applied to psychotherapy, is still disquietingly vague’; and, that ‘all questions appertaining to the need for psychotherapeutic services must be examined . . . (in relation to) . . . the most pressing problems of ill health in the general population’. I suggest that it is likely to be against this background that health service planners, the community, and most doctors, will consider the economic appraisal of psychotherapy.

Secondly, Aveline's account of the economic ‘reality of NHS psychotherapy’ is unconvincing. Economic appraisal depends upon the availability of reliable and valid information, which, in this case, is obviously lacking. His assessment that ‘The cost of psychotherapy is not great’ and that ‘a modest investment would secure essential training . . . (in psychotherapeutic methods) . . . for psychiatrists, nurses, and others’ is not accompanied by any evidence. Examine his statements alongside the results of a preliminary American survey (since there is no comparable British work) (23), which found that psychiatrists, psychologists, and social workers reported spending 30 per cent of their time on psychotherapy, and primary-care physicians reported spending 10 per cent of their time in this way. No figures were produced for the probably enormous amount of time spent on psychotherapeutic activities, of every shape and form, by psychiatric and mental health nurses, and counsellors or ministers of religion, not to mention volunteers. These ‘hidden’ costs are, perhaps not surprisingly, hardly ever considered by those seeking to promote psychotherapy.

Thirdly, Aveline states that ‘Arguments in favour of the cost benefit of psychotherapy must not obscure the fact that there is no alternative treatment for major problems of relationship’. This remark is so ill-defined clinically as to be practically incomprehensible; and, from an economic standpoint appears to take no account either of opportunity cost (what benefits are foregone by using resources to fund psychotherapy) or of an alternative treatment (namely, a placebo). The fact is that there is no definitive favourable evidence regarding the clinical and economic effectiveness of psychotherapy for patients with mental disorders.

Ethical considerations

The two main issues that arise here are: 1) the regulation of practitioners of psychoanalytic psychotherapies; 2) the safeguarding of the interests of the vulnerable patients receiving such treatment.

To begin with, consider the revealing foreword to *Statutory Registration of Psychotherapists. A Report of a Professions Joint Working Party*, written by a lawyer,

Sieghart (24). ‘At the moment, there is no law of any kind . . . (in Britain) . . . which determines who may call himself a psychotherapist (or a psychoanalyst, an analytical or clinical psychologist, or anything else of that kind), or what people who call themselves such things may do to (or with) their patients. I could set up tomorrow as a psychotherapist and call myself anything I liked, without having received any training, holding any qualifications, or belonging to any professional body – and no one could stop me. I could advertise my services in any terms and charge my patients whatever I could get out of them for as long as I could persuade them to stay with me. Provided they were above the appropriate age of consent (16 for women, 21 for men), and did consent, I could go to bed with them. Only if a patient could prove in a civil court that I had done him some positive and ascertainable harm, because I did not exercise enough skill and care in his treatment, might I be ordered to pay him damages, but even then no one could stop me from carrying on my practice’.

It may be recalled that medical practitioners, pharmacists, nurses, midwives, opticians, dispensers of hearing aids, chiropodists, dietitians, medical laboratory technicians, occupational therapists, orthoptists, physiotherapists, radiographers and remedial gymnasts have all achieved statutory recognition.

Moreover, Sir John Foster, in his wide-ranging *Enquiry into the Practice and Effects of Scientology* (25), which dealt at some length with psychotherapy, stated quite bluntly that ‘the possibilities of harm to the patient from the abuse, or the unskilled use, of these . . . (psychotherapeutic) . . . techniques are at least as great as the possibilities of good in the right hands’. He also emphasised a crucial point: ‘it will not have escaped attention that those who feel they need psychotherapy tend to be the very people who are most easily exploited: the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed, whose desperation is often such that they are willing to do and pay anything for some improvement of their condition’.

Ethical considerations in relation to health economics

Various aspects of choosing priorities in health care touch on medical ethics (26, 27). In Mooney's (28) persuasive assessment ‘It is not a question of ethics or economics. Without a wider use of economics in health care, inefficiencies will abound and decisions will be made less explicitly and hence less rationally than is desirable . . . The price of inefficiency, inexplicitness and irrationality in health care is paid in death and sickness. Is that ethical?’ Essentially, health economics contains a concept of social ethics as well as of individual ethics (29, 30), and this is the context in which the use of psychoanalysis, and allied techniques, within the health service requires to be justified.

Tancredi and Slaby (1) go straight to the heart of the

matter: 'Psychoanalysis is highly expensive and limited in its application to integrated, wealthy, and functioning individuals who are interested in learning more about themselves, or who need to relate their personal problems to a strong figure. The disconcerting aspect of psychoanalysis is that it drains resources from the care of seriously mentally ill patients'. One of the very few texts dealing specifically with the theme of *Ethics and Values in Psychotherapy* (31) has, typically, virtually nothing to say about such matters.

Conclusion

I question the place of psychoanalysis and psychoanalytically oriented psychotherapy in the health service. There are pressing clinical, research, economic, and ethical reasons in support of the contention that an urgent review of the extent and impact of psychoanalytic practices in the National Health Service is called for. This undertaking is in the domain of the Department of Health and Social Security, one of whose priorities is to ensure the provision of efficient and effective mental health services within the context of general health services.

Dr Greg Wilkinson MRCP, MRCPsych is Honorary Lecturer in the General Practice Research Unit at the Institute of Psychiatry, De Crespigny Park, London SE5 8AF

References

- (1) Tancredi L R, Slaby A E. *Ethical policy in mental health care: the goals of psychiatric intervention*. London: William Heinemann Medical Books Ltd, 1977.
- (2) Shepherd M. Psychoanalysis, psychotherapy, and health services. *British medical journal* 1979; 2: 1557-1559.
- (3) Dare C. Psychoanalysis. In: Harré R, Lamb R, ed. *The encyclopedic dictionary of psychology*. Oxford: Blackwell Reference, 1983.
- (4) Royal College of Psychiatrists. Norms for medical staffing of a psychotherapy service for a population of 200,000. *Bulletin of the Royal College of Psychiatrists* 1975 October: 4-9.
- (5) Cooper B. Psychotherapy, psychiatric epidemiology and health services. *Social psychiatry* 1984; 19: 93-95.
- (6) Anonymous. Psychotherapy: effective treatment or expensive placebo? [editorial]. *Lancet* 1984; 1: 83-84.
- (7) Shepherd M. What price psychotherapy? *British medical journal* 1984; 288: 809-810.
- (8) Wilkinson G. Psychotherapy in the market-place. *Psychological medicine* 1984; 14: 23-26.
- (9) Gwynne Jones H. Psychotherapy research. *Journal of the Royal Society of Medicine* 1985; 78: 3-6.
- (10) Prioleau L, Murdock M, Brody N. An analysis of psychotherapy versus placebo studies. *The behavioural and brain sciences* 1983; 6: 275-310.
- (11) Bloch S, Lambert M J. What price psychotherapy? A rejoinder. *British journal of psychiatry* 1985; 146: 95-98.
- (12) Ryle A. How can we compare different psychotherapies? Why are they all effective? *The British journal of medical psychology* 1984; 57: 261-264.
- (13) Malan D H. The outcome problem in psychotherapy research. A historical review. *Archives of general psychiatry* 1973; 29: 719-729.
- (14) Kernberg O F, Burstein E D, Coyne L, Appelbaum A, Horwitz L, Voth H. Psychotherapy and psychoanalysis. Final report of the Menninger Foundation's Psychotherapy Research Project. *Bulletin of the Menninger Clinic* 1972; 36: 3-275.
- (15) Sloane R B, Staples F R, Cristol A H, Yorkston N J, Whipple K. *Psychotherapy versus behaviour therapy*. Cambridge, Mass: A Commonwealth Fund Book, Harvard University Press, 1975.
- (16) Shepherd M, Cooper B, Brown A C, Kalton G. *Psychiatric illness in general practice*. Oxford: Oxford University Press, 1966.
- (17) Brodaty H, Andrews G. Brief psychotherapy in family practice. A controlled prospective intervention trial. *British journal of psychiatry* 1983; 143: 11-19.
- (18) Crisp A H, Hemsi L K, Paykel E S, Storey P B, Beary M D, Kerr D L. A future pattern of psychiatric services and its educational implications: some suggestions. *Medical education* 1984; 18: 110-116.
- (19) Hicks D. *Primary health care. A review*. London: Her Majesty's Stationery Office, 1976.
- (20) Sowerby P. The doctor, his patient, and the illness: a reappraisal. *Journal of the Royal College of General Practitioners* 1977; 27: 583-589.
- (21) Madden T A. The doctors, their patients and their care: Balint reassessed. *Psychological medicine* 1978; 9: 5-8.
- (22) Aveline M. What price psychiatry without psychotherapy? *Lancet* 1984; 2: 856-859.
- (23) Beitman B D. The demographics of American psychotherapists: a pilot study. *American journal of psychotherapy* 1983; 37: 37-48.
- (24) Sieghart P. *Statutory registration of psychotherapists. A report of a professions joint working party*. Cambridge: E E Plummer, 1978.
- (25) Foster Sir J. *Enquiry into the practice and effects of scientology*. London: Her Majesty's Stationery Office, 1971.
- (26) Habgood J. The ethics of resource allocation: a case study. *Journal of medical ethics* 1983; 9: 21-24.
- (27) Boyd K M. The ethics of resource allocation. *Journal of medical ethics* 1983; 9: 25-27.
- (28) Mooney G H. Cost-benefit analysis and medical ethics. *Journal of medical ethics* 1980; 6: 177-179.
- (29) Williams A. Medical ethics. Health service efficiency and clinical freedom. In: Culyer A J, ed. *Nuffield/York portfolios*, folio 2. London: Nuffield Provincial Hospital's Trust. Undated.
- (30) Mooney G H. Medical ethics: an excuse for inefficiency? *Journal of medical ethics* 1984; 10: 183-185.
- (31) Rosenbaum M, ed. *Ethics and values in psychotherapy. A guidebook*. New York: The Free Press, 1982.